MARKET CONDUCT EXAMINATION REPORT

AS OF DECEMBER 31, 2002

Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, NE 68131

NAIC Group Code 367
NAIC Company Code 80578

EXAMINATION PERFORMED BY INDEPENDENT CONTRACTORS FOR

COLORADO DEPARTMENT OF REGULATORY AGENCIES
DIVISION OF INSURANCE

Physicians Mutual Insurance Company
2600 Dodge Street
Omaha, NE 68131

MARKET CONDUCT EXAMINATION REPORT
as of
December 31, 2002

Examination Performed by

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP
Lynn L. Zukus, AIE, FLMI

Independent Contract Examiners

February 6, 2004

The Honorable Doug Dean
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Physicians Mutual Insurance Company was conducted pursuant to Sections 10-1-203, 10-1-204, 10-1-205(8), 10-3-1106, and 10-16-216, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine insurance companies. We examined the Company's records at its office located at 2600 Dodge Street, Omaha, NE 68131. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The results of the examination are respectfully submitted by the following independent market conduct examiners.

Sarah S. Malloy, CIE, AIRC, PAHM, HIA, LTCP

Lynn L. Zukus, AIE, FLMI

MARKET CONDUCT EXAMINATION REPORT OF PHYSICIANS MUTUAL INSURANCE COMPANY

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COMPANY PROFILE

Physicians Mutual Insurance Company is a mutual company operated for the benefit of its policyholders and is licensed to do business in all fifty (50) states and the District of Columbia. The Company was issued a Certificate of Authority to conduct business in Colorado effective June 10, 1963.

Physicians Mutual Insurance Company provides an Individual Major Medical PPO product that is offered through Company agents. During 2002, the PPO was available in 11 states, including Colorado.

The Company's Accident and Health direct written premium in Colorado for 2002 was $9,681,000, representing 0.55% of the market share. The Company's loss ratio in Colorado for 2002 was 59.92%.

Best's Insurance Reports – L/H, 2003 Edition assigned a Best's Rating of A (Excellent) to Physicians Mutual Insurance Company. The Company was assigned the Financial Size Category of Class X which is the Financial Size Category of the parent.

PURPOSE AND SCOPE OF EXAMINATION

Independent examiners, contracting with the Colorado Division of Insurance (DOI), in accordance with Sections 10-1-202, 10-1-203, 10-1-204, C.R.S., which empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Physicians Mutual Insurance Company. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to individual sickness and accident insurance laws. Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the limited examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The market conduct examination covered the period from January 1, 2002 through December 31, 2002.

The limited examination included review of the following:

Company Operations/Management
Policy Forms
Rating
Applications
Cancellations/Non-Renewals/Declinations
Claims
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero ($0) tolerance level was applied in order to identify possible system errors. Additionally a zero ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception

rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

For the period under examination, the examiners included statutory citations and regulatory references related to individual insurance laws. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance company or insurance product.

EXAMINERS' METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and Colorado regulations. For this examination, special emphasis was given to the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1104	Unfair methods of competition and unfair or deceptive acts or practices
Section 10-8-513	Eligibility for coverage under the program
Section 10-8-521	Notice to residents
Section 10-8-601.5	Applicability and Scope
Section 10-8-602	Definitions
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Section 10-20-102	Legislative declaration
Section 10-20-103	Definitions
Amended Regulation 1-1-6	Concerning the Elements of Certification for Accident and Health Forms, Automobile Private Passenger Forms, and Claims-Made Liability Forms
Regulation 1-1-7	Market Conduct Record Retention
New Regulation 1-1-8	Penalties And Timelines Concerning Division Inquiries And Document Requests
Repromulgated Regulation 4-2-1	Replacement Of Accident And Sickness Insurance
Regulation 4-2-5	Hospital Definition
Amended Regulation 4-2-6	Concerning The Definition Of The Term "Complications Of Pregnancy"
Amended Regulation 4-2-8	Concerning Required Health Insurance Benefits for Home Health Services and Hospice Care
Amended Regulation 4-2-11	Rate Filing and Annual Report Submissions Health Insurance
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Amended Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Amended Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions

Amended Regulation 4-2-19	Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One
Amended Regulation 4-2-20	Concerning The Colorado Comprehensive Health Benefit Plan Description Form
New Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Amended Regulation 4-6-3	Concerning CoverColorado Standardized Notice Form And Eligibility Requirements
Amended Regulation 4-6-5	Implementation of Basic and Standard Health Benefit Plans
Regulation 4-6-9	Conversion Coverage
Amended Regulation 5-2-3	Auto Accident Reparations Act (No-Fault) Rules and Regulations

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, and timely cooperation with the examination process.

Policy Forms

The examiners reviewed the following Policy Forms, Application, Endorsements and Rider Forms.

FORM NUMBER	FORM NAME
P283CO	Individual Major Medical Policy with Schedule
A281CO	Application
PM-1944CO	Application Addendum
AM5-1296	Application Addendum
B083	Maternity Rider
B111	Supplemental Accident Rider
PM-749-0787	Notice to Applicant Regarding Replacement
B106	Hospice and Health Care Rider
PM-1790	Determination of Self-Employed Business Group of One Form
CLM-PMIC	Claim Form
CMS 1500	Health Insurance Claim Form
PM-749-0787	Notice to Applicant Regarding Replacement of Accident and Health Insurance
None	CoverColorado Notice Form (Company uses a letter)

The most frequently sold individual plan in Colorado in 2002 was the Individual Major Medical Policy, Form P283CO.

Rating

The examiners reviewed a randomly selected sample of the rates charged in the sample of files used in the Underwriting-Application section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period.

Applications

For cases that were initially effective or renewed during the period from January 1, 2002 through December 31, 2002, the examiners used ACL ™ software to randomly select 100 individual (50 new and 50 renewal business) application files. These files were reviewed for compliance with Colorado insurance law.

Cancellations/Non-Renewals/Declinations

For individual cases that terminated (were cancelled, non-renewed, rescinded or declined) during the period under examination, the examiners used ACL ™ software to randomly select a sample of fifty (50) cancelled/non-renewed files and fifty (50) declined files. The population of two (2) rescinded files was used as the sample. These files were reviewed to determine if the procedures used for cancellations, non-renewals, declinations and rescissions were in compliance with Colorado insurance law and contractual obligations.

Claims

The examiners used ACL ™ software to randomly select samples of electronically received and non-electronically received individual claims that were reviewed for timeliness of processing only. Additionally, any claims absent fraud that were not paid, denied or settled within ninety (90) days of receipt were identified. Valid exceptions in all of these categories were included in one issue.

The examiners used ACL ™ software to randomly select samples of fifty (50) Paid claims and fifty (50) Denied claims that were reviewed for the Company's overall claims handling practices. These claims were all received during the examination period of January 1, 2002 through December 31, 2002.

Utilization Review

The Company indicated that it did not conduct, nor have any entity conduct for it, Utilization Review during 2002. Utilization Review had been discontinued by the Company in 2001. As a result, there were no files to be examined.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-two (22) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

- **Company Operations/Management:** The examiners found two (2) areas of concern in their review of company operations and management. The following issues were identified:

  1. Failure to maintain an access plan as required by Colorado insurance law.

  2. Certifying and using forms that do not comply with Colorado insurance law.

  It is recommended that procedures be established to ensure that an Access Plan is maintained by the Company for each managed care network that the Company utilizes in Colorado and that the Access Plan reflects complete and correct procedures and processes. It is also recommended that the Company develop, implement, and monitor the necessary procedures to ensure that all forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company.

- **Policy Forms:** The examiners found fifteen (15) areas of concern in their review of the most frequently sold individual policy forms in use during the year under examination. The following issues were identified:

  1. Failure to provide benefits for covered services based on a licensed provider's status, (e.g., a family member or residing in the home of the insured).

  2. Failure to reflect correct or complete benefits for mammography screening.

  3. Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.

  4. Failure to display a Fraud Warning that is substantially the same as required by Colorado insurance law.

  5. Failure to disclose the existence and availability of an access plan in the most frequently sold policy in Colorado.

  6. Failure to reflect correct information in the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance".

  7. Failure to reflect correct information in application forms concerning replacement of coverage.

  8. Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

9. Failure to reflect correctly the criteria for and the extent of coverage to be provided for home health services and hospice care.

10. Failure to reflect correct or complete preventive child health supervision service benefits.

11. Failure to reflect correct information in the CoverColorado Notice Form.

12. Failure to reflect correct information concerning non-renewal of health benefit plans.

13. Failure to reflect correct information concerning coverage for preexisting conditions.

14. Failure to reflect a correct limiting age for full-time students to remain covered as dependents.

15. Failure to reflect correct or complete questions on the form used for determining whether or not an applicant is a self-employed business group of one.

It is recommended that the Company review and revise all applicable policy forms to comply with individual sickness and accident laws and regulations.

- **Rating:** The examiners found no areas of concern in their review of the rates and associated required rate filings.

- **Applications:** The examiners found one (1) area of concern in their review of application files for the examination period.

    1. Failure to use required disclosure forms to allow exemption from provisions required of small group plans when selling individual plans to Business Groups of One.

    It is recommended that the Company establish procedures to ensure that the necessary forms are obtained from and the required health plan description form is given to applicants that are Business Groups of One.

- **Cancellations/Non-Renewals/Declinations:** The examiners found one (1) area of concern during the review of the cancellation/non-renewal/declination files. The following issue was identified:

    1. Failure to send Certificates of Creditable Coverage within a reasonable time period.

    It is recommended that the Company establish procedures to ensure that Certificates of Creditable Coverage are processed within a reasonable time period in compliance with Colorado insurance law.

- **Claims:** The examiners found three (3) areas of concern in their review of the claims handling practices of the Company. The following issues were identified:

1. Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

2. Failure to accurately determine the number of days utilized for claim processing.

3. Failure, in some cases, to accurately process claims.

It is recommended that the Company establish procedures to ensure payment, denial or settlement of claims within the time periods required by law. Additionally procedures should be established to ensure that the number of days utilized for claim processing is calculated correctly and claim procedures should be reviewed to ensure accuracy of payment in all cases.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance.

Results of any previous Market Conduct Exams are available on the Colorado Division of Insurance's website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

PHYSICIANS MUTUAL INSURANCE COMPANY

COMPANY OPERATIONS / MANAGEMENT FINDINGS

Issue A1: Failure to maintain an access plan as required by Colorado insurance law.

Section 10-16-704(9), C.R.S., Network adequacy, states:

> Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204(3), C.R.S., *available on its business premises and shall provide them to any interested party upon request*. [Emphasis added.] In addition, all health benefit plans and marketing materials shall clearly disclose the existence and availability of the access plan. All rights and responsibilities of the covered person under the health benefit plan, however, shall be included in the contract provisions, regardless of whether or not such provisions are also specified in the access plan. The carrier shall prepare an access plan prior to offering a new managed care network and shall update an existing access plan whenever the carrier makes any material change to an existing managed care network, but not less than annually. The access plan of a carrier offering a managed care plan *shall demonstrate the following*: [Emphasis added.]
>
> (a.9) If the covered person has a pharmacy benefit, an adequate number of pharmacy providers within a reasonable distance, travel time, delivery time, or all three. Nothing in this paragraph (a.9) shall preclude the use of a retail or mail-order pharmacy provider.
>
> (b) A carrier offering a managed care plan shall maintain procedures for making referrals within and outside its network that, at a minimum, must include the following:
>
> (II) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services;
>
> (III) Timely referrals for access to specialty care;
>
> (IV) A process for expediting the referral process when indicated by medical condition; and
>
> (V)(A) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;
>
> (B) A provision that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.
>
> (c) The carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;
>
> (d) The carrier's quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;
>
> (e) The carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(f) The carrier's methods for determining the health care needs of covered persons, tracking and assessing clinical outcomes from network services, and evaluating consumer satisfaction with services provided;
(g) The carrier's method for informing covered persons of the plan's services and features, including but not limited to the following:
(I) The plan's grievance procedures, which shall be in conformance with division rules concerning prompt investigation of health claims involving utilization review and grievance procedures;
(II) The extent to which specialty medical services, including physical therapy, occupational therapy, and rehabilitation services are available;
(III) The plan's process for choosing and changing network providers; and
(IV) The plan's procedures for providing and approving emergency and medical care;
(h) The carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;
(i) The carrier's process for enabling covered persons to change primary care professionals;
(j) The carrier's proposed plan for providing continuity of care in the event of contract termination between the carrier and any of its participating providers or in the event of the carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner.

In response to the request for copies of the Company's Access Plan, the examiners were provided a document titled "Managed Care Accessibility Analysis", used in 2002, for Sloans Lake Managed Care PPO Network. This "Analysis" does not appear to meet the requirement to maintain an Access Plan that reflects the carrier's procedures and processes with regards to the rights of a covered person as specified in paragraphs (a) to (j) of subsection (9) of Section 10-16-704, C.R.S.

Recommendation No. 1:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure compliance with Colorado insurance law in maintaining and making available an access plan for each managed care network offered in Colorado.

Issue A2: Certifying and using forms that do not comply with Colorado insurance law.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> (1)(s) Certifying pursuant to section 10-16-107.2 or issuing, soliciting, or using a policy form, endorsement, or rider that does not comply with statutory mandates. Such solicitation or certification shall be subject to the sanctions described in sections 10-2-704, 10-2-801, 10-2-804, 10-3-1107, 10-3-1108, and 10-3-1109.

An officer of the Company must certify compliance with Colorado insurance law with all initial filings of policy forms and on the annual report of policy forms. It appears that the Company is not in compliance with Colorado insurance law in that not all forms that were certified and used by the Company were in compliance with statutory mandates as evidenced by Issues E1 through E15.

Recommendation No. 2:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that evidence of coverage forms to be issued or delivered to Colorado insureds comply with statutory mandates as certified to by an officer of the Company, and as required by Colorado insurance law.

UNDERWRITING
POLICY FORMS
FINDINGS

Issue E1: Failure to provide benefits for covered services based on a licensed provider's status, (e.g., a family member or residing in the home of the insured).

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers

(a) Sickness and accident insurance.

(I) (A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan shall not be denied when such service is rendered by a person so licensed. …

The Company's most frequently sold policy in Colorado in 2002 reflects an exclusion that does not appear to be in compliance with Colorado insurance law. A policy may not exclude reimbursement for covered services performed by a licensed provider if the services are within the scope of the provider's license, and the provider normally charges for the services.

The wording on page 3 and page 6 of the policy is:

DEFINITIONS

PHYSICIAN. A licensed medical practitioner who:

(1) is acting within the lawful scope of his or her license:
(2) is not living with the Covered Person; and
(3) is not related to the Covered Person by blood or marriage.

The wording on page 9 and page 10 of the policy is:

COVERED CHARGES

(6) Nursing Services. The professional Nursing Services by a licensed nurse (R.N., L.P.N., or L.V.N.) who is not:

(a) living with the Covered Person; or
(b) related to the Covered Person by blood or marriage.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 3:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect, as required by Colorado insurance law, that benefits may not be denied solely based on a provider's status, e.g., a family member or residing with the insured.

Issue E2: Failure to reflect correct or complete benefits for mammography screening.

Section 10-16-104, C.R.S., Mandatory Coverage Provisions, states:

> (4) Low-dose mammography.
>
> (a) For the purposes of this subsection (4), "low-dose mammography" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and film and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast. All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage provided to residents of this state, shall provide coverage for *routine and certain diagnostic screening* by low-dose mammography for the presence of breast cancer in adult women. *Routine and diagnostic screenings* provided pursuant to subparagraph (II) or (III) of this paragraph (a) shall be provided on a contract year or a calendar year basis by entities subject to part 2 or 3 of this article and *shall not be subject to policy deductibles*. Such coverages shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. *The minimum benefit required under this subsection (4) shall be adjusted to reflect increases and decreases in the consumer price index*. Benefits for routine mammography screenings shall be determined on a calendar year or a contract year basis, which shall be specified in the policy or contract. The routine and diagnostic coverages provided pursuant to this subsection (4) shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. … [Emphases added.]
>
> (b) The requirements of this section shall apply to all individual sickness and accident insurance policies and health care service or indemnity contracts issued on or after July 1, 1995, …

The Company's most frequently sold policy in Colorado in 2002 does not appear to reflect correct or complete information concerning the mandated coverage to be provided for mammography in the following ways:

<u>Incorrect</u>

(1) Mammograms are reflected as a Preventive Care Service in the policy and there is a one hundred eighty day waiting period from the effective date of the policy for these services. Colorado insurance law does not require coverage to have been in effect for six (6) months before this mandated benefit be provided.

(2) The word "diagnostic" is the only descriptive word in the policy for the mammography benefit. The required coverage for mammograms in Colorado insurance law includes routine screenings as well as diagnostic screenings.

Incomplete

(1) There is nothing reflected concerning the minimum benefit amount for mammograms, adjusted to reflect increases and decreases in the consumer price index. From September 1, 2001 through August 31, 2002 the minimum benefit amount was $75.62 and from September 1, 2002 through August 31, 2003 the minimum benefit amount was $76.60.

The wording on page 10 of the policy is:

> (7) Preventive Care Services. Covered Charges are subject to a one hundred eighty (180) day waiting period from the Effective Date of the Policy, except for covered dependents under the age of two (2).
>
> (d) Mammograms. Diagnostic mammograms are covered as follows, or more often if recommended by an attending Physician:
>
> (i) one (1) baseline mammogram for women ages thirty-five (35) through thirty-nine (39) years of age; and
> (ii) one (1) mammogram every year for women forty (40) years of age and older.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 4:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its individual policy forms to ensure compliance with Colorado insurance law in reflecting correct and complete benefits that are mandated for mammography screening.

Issue E3: Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(10) Prostate cancer screening.

(a) All individual and all group sickness and accident insurance policies, except supplemental policies covering a specified disease or other limited benefit, which are delivered or issued for delivery within the state by an entity subject to the provisions of part 2 of this article and all individual and group health care service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article, as well as any other group health care coverage offered to residents of this state, shall provide coverage for annual screening for the early detection of prostate cancer in men over the age of fifty years and in men over the age of forty years who are in high-risk categories, which coverage by entities subject to part 2 or 3 of this article shall not be subject to policy deductibles. Such coverage shall be the lesser of sixty-five dollars per prostate cancer screening or the actual charge for such screening. Such benefit shall in no way diminish or limit diagnostic benefits otherwise allowable under a policy. …

The Company's most frequently sold policy in Colorado in 2002 reflects the prostate cancer screening benefit under Preventive Care Services. A waiting period of one hundred eighty days from the effective date of the policy is reflected as a requirement for covered charges for these services. This does not appear to be in compliance with Colorado insurance law that does not require coverage to have been in effect for six (6) months before this mandated benefit be provided.

The wording on page 10 and page 11 of the policy is:

(7) Preventive Care Services. Covered Charges are subject to a one hundred eighty (180) day waiting period from the Effective Date of the Policy, except for covered dependents under the age of two (2).

(e) Prostate Cancer Screening. We will pay Covered Charges for Prostate Cancer Screening up to a maximum of sixty-five ($65) dollars per screening.

Such charges include:

(i) The screening shall be performed by a qualified medical professional, including without limitation a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or Physician assistant;

(ii) The screening shall consist, at a minimum A (sic) prostate-specific antigen (PAS) blood test or a digital rectal examination;

(iii) At least one (1) screening per year shall be covered for any man fifty (50) years of age or older; and

(iv) At least one (1) screening per year shall be covered to (sic) any man from

forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by the Physician.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 5:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to reflect an accurate description of the mandated coverage for prostate cancer screening.

Issue E4: Failure to display a Fraud Warning that is substantially the same as required by Colorado insurance law.

Section 10-1-127, C.R.S., Fraudulent insurance acts – immunity for furnishing information relating to suspected insurance fraud – legislative declaration, states:

(7)(a) On and after January 1, 1997, each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:

> "It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

The Company has indicated that it uses the Claim Form for displaying the "Fraud Warning" statement. This "Fraud Warning" on the PPO claim form does not appear to be in compliance with Colorado insurance law as the wording is not substantially the same as reflected in Colorado insurance law. The wording is correct and complete on the non-PPO claim forms.

The wording on the two (2) PPO claim forms provided by the Company is:

> Any person who knowingly files a statement of claim containing any material omission or false or misleading information is subject to criminal and civil penalties.

Form Number	Form Name
CLM-PMIC	Claim Form
CMS 1500	Health Insurance Claim Form

Recommendation No. 6:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-1-127, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms that display the required Fraud Warning statement to reflect substantially the same wording as required by Colorado insurance law.

Issue E5: Failure to disclose the existence and availability of an access plan in the most frequently sold policy in Colorado.

Section 10-16-704, C.R.S., Network adequacy, states:

> (9) Beginning January 1, 1998, a carrier shall maintain and make available upon request of the commissioner, the executive director of the department of public health and environment, or the executive director of the department of health care policy and financing, in a manner and form that reflects the requirements specified in paragraphs (a) to (k) of this subsection (9), an access plan for each managed care network that the carrier offers in this state. The carrier shall make the access plans, absent confidential information as specified in section 24-72-204 (3), C.R.S., available on its business premises and shall provide them to any interested party upon request. In addition, *all health benefit plans* and marketing materials *shall clearly disclose the existence and availability of the access plan*. … [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that its most frequently sold health benefit plan does not clearly disclose the existence and availability of an access plan for its Sloans Lake PPO network.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 7:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-704, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its health benefit plans to clearly disclose the existence and availability of an access plan for its Sloans Lake PPO network.

Issue E6: Failure to reflect correct information in the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance".

Repromulgated Regulation 4-2-1, REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

D. Upon determining that a sale will involve replacement of accident and sickness insurance, any issuer, other than a direct response issuer, or its producer, shall furnish the applicant, prior to issuance or delivery of the accident and sickness insurance policy or contract, a notice regarding replacement of accident and sickness insurance. One (1) copy of such notice signed by the applicant *and producer,* except where the coverage is old (sic) without a producer, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. [Emphasis added.] …

E. The Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) required by Subsection D above for an issuer, shall be provided in the format prescribed and adopted by the Commissioner of Insurance.

F. Paragraphs 1 and 2, contained in such Notice to the Applicant Regarding Replacement of Accident and Sickness Insurance, (applicable to preexisting conditions), in Appendix A, may be deleted by the issuer if the replacement does not involve the application of a new preexisting condition limitation.

G. Failure to comply with the requirements of this Section 5 constitutes an unfair method of competition and an unfair or deceptive act or practice in the business of insurance which is prohibited under §10-3-1104, C.R.S.

Appendix A

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT
AND SICKNESS INSURANCE
(Insurance company's name and address)

According to (your application) (the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide [Number days of free look period, if any] days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits

_____ No change in benefits and lower premiums

_____ Fewer benefits, but lower premiums

_____ Other. (please specify)

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. {If the policy or contract is guaranteed issued this paragraph need not appear].

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Producer or Other Representative)*
[Typed Name and Address of Issuer or Producer]

*Signature not required for direct response sales.

The form used by the Company for a Notice to Applicant Regarding Replacement of Accident and Sickness Insurance (Appendix A) does not appear to be complete or to be in the format prescribed and adopted by the Commissioner of Insurance.

Incomplete

1) Although there is a signature line for the applicant, there is no signature line or place for the typed name and address of the issuer or producer.

2) There is no Statement To Applicant By Issuer Or Producer.

3) The following sentence is not reflected:
"Do not cancel your present policy until you have received your new policy and are sure that you want to keep it."

4) Nothing is reflected concerning a free look period, however the policy states on Page 1, that there is a thirty-one (31) day period after receipt for examination, and if the insured returns the policy within these thirty-one (31) days it is void and premium will be returned.

Non-compliant Format

1) Item 2 of the Company's Form reads:
You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present policy.

Form Number	Form Name
PM-749-0787	Notice To Applicant Regarding Replacement of Accident And Health Insurance

Recommendation No. 8:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Repromulgated Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its "Notice To Applicant Regarding Replacement of Accident And Health Insurance" to reflect correct information as required by Colorado insurance law.

Issue E7: Failure to reflect correct information in application forms concerning replacement of coverage.

Repromulgated Regulation 4-2-1, REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE, promulgated under the authority of §§10-1-109 and 10-3-1110, Colorado Revised Statutes (C.R.S.) states:

Section 2. Purpose

The purpose of this regulation is to safeguard the interests of persons covered by individual accident and sickness insurance policies or plans who consider replacement of their coverage by making available to them information regarding replacement and thereby reducing the opportunity for misrepresentation and other unfair practices and methods of competition in the business of insurance.

Section 5. Rules

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has accident and sickness insurance in force or whether accident and sickness insurance is intended to replace or be in addition to any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements may be used.

[Statements]

(1) You normally do not require more than one policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy.

(4) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

[Questions]

To the best of your knowledge:

(3) Are you *covered* for medical assistance through the state Medicaid program: [Emphasis added.]

a. As a Specified Low Income Medicare Beneficiary (SLMB)?

b. As a Qualified Medicare Beneficiary (QMB)?

c. For other Medicaid medical benefits?

The Company's application for insurance does not appear to reflect any of the required statements, and one of the questions required by Colorado insurance law reflects incorrect/incomplete information. No supplementary application or other form used for this purpose was provided to the examiners. Question 3 is not complete nor is it correct as it asks if the applicant is eligible for Medicaid or Medicare, instead of if the applicant is covered through the state Medicaid program and does not reflect any of the three (3) ways an applicant could be covered.

Form Number	Form Name
A281CO	Application For Insurance

Recommendation No. 9:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Repromulgated Regulation 4-2-1. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its application forms to reflect correct and complete information concerning replacement of coverage as required by Colorado insurance law.

Issue E8: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

> (1.7) Therapies for congenital defects and birth abnormalities.
>
> (a) After the first thirty-one days of life, policy limitations and exclusions that are generally applicable under the policy may apply; except that all individual and group health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five years of age.
>
> (b) The level of benefits required in paragraph (a) of this subsection (1.7) *shall be the greater of the number of such visits provided under the policy or plan or twenty therapy visits per year each for physical therapy, occupational therapy, and speech therapy*. Said therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy or yearly term of the enrollee coverage contract, without regard to whether the condition is acute or chronic and *without regard to whether the purpose of the therapy is to maintain or to improve functional capacity*. [Emphases added.]

The Company's most frequently sold plan in Colorado in 2002 does not appear to reflect an accurate description of the therapies as mandated by Colorado insurance law for congenital defects and birth abnormalities for children in the following ways:

1. This therapy is to be provided without regard as to whether the purpose is to maintain or improve functional capacity. The Benefit Provisions of the policy indicate that occupational and physical therapy must be to improve a body function.

2. The minimum level of benefits required to be available is twenty (20) visits per year for each of three types of therapy and this correlates to sixty visits. The Schedule of Benefits for the policy reflects a calendar year benefit maximum for each covered person of thirty visits for a combination of speech, occupational, or physical therapy.

The wording on page 7 and page 12 of the policy is:

BENEFIT PROVISIONS

BENEFIT PAYMENT. We will pay the Coinsurance amount after all Deductibles or Copayments have been met for Covered Charges incurred by a Covered Person, due to an Injury or Sickness. The benefits payable are subject to all the terms, conditions, limitations, and Exclusions listed in the Policy, as well as the Coinsurance, Deductibles, Copayment amounts and Benefit Maximums shown in the Schedule.

(14) Speech, Occupational, or Physical Therapy. Covered Charges include services of a licensed therapist.

(c) Occupational and Physical Therapy must be:

(ii) to improve a body function.

The wording on page 22 of the policy is:

SCHEDULE P283CO
PREFERRED CHOICE FOR INDIVIDUALS

CALENDAR YEAR BENEFIT MAXIMUMS (for each Covered Person)

Speech, Occupational, or Physical Therapy-Combined [30 visits]

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 10:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable policy forms to reflect accurate information concerning the mandated therapies required by Colorado insurance law be provided for congenital defects and birth abnormalities for children.

Issue E9: Failure to reflect correctly the criteria for and the extent of coverage to be provided for home health services and hospice care.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(7) Reimbursement of providers.

(a) Sickness and accident insurance.

(I)(A) Notwithstanding any provisions of any policy of sickness and accident insurance issued by an entity subject to the provisions of part 2 of this article or a prepaid dental care plan subject to the provisions of part 5 of this article, whenever any such policy or plan provides for reimbursement for any service that may be lawfully performed by a person licensed in this state for the practice of osteopathy, medicine, dentistry, dental hygiene, optometry, psychology, chiropractic, or podiatry, reimbursement under such policy or plan *shall not be denied when such service is rendered by a person so licensed.* …[Emphasis added.]

(II) The provisions of subparagraph (I) of this paragraph (a) shall apply:

(A) To all individual sickness and accident policies issued on and after July 1, 1973.

(8) Availability of hospice care coverage.

(d) The commissioner, in consultation with the department of public health and environment, may establish by rule and regulation requirements for standard policy and plan provisions which state *clearly and completely the criteria for and extent of insured coverage for home health services* and hospice care. Such provisions shall be designed to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Amended Regulation 4-2-8, Concerning Required Health Insurance Benefits For Home Health Services And Hospice Care, promulgated under the authority of Sections 10-1-109 and 10-16-104(8)(d), C.R.S., states:

Section 2. Purpose

The purpose of this regulation is to establish requirements for standard policy provisions, which *state clearly and completely the criteria for and extent of coverage for home health services* and hospice care and to facilitate prompt and informed decisions regarding patient placement and discharge. [Emphasis added.]

Section 4. Requirements for Home Health Services

B. General Policy Provisions Pertaining to Home Health Care.

(1) The policy offering shall provide that home health services are to be covered when such services are necessary as alternatives to hospitalization or in place of hospitalization. *Prior hospitalization shall not be required*. [Emphasis added.]

Section 5. Requirements for Hospice Care

A. Definitions.

(4) *A "patient/family" is one unit of care consisting of those individualswho are closely linked with the patient, including the immediate family, the primary care giver and individuals with significant personal ties*. [Emphasis added.]

(12) *"Home care services" are hospice services, which are provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility*. [Emphasis added.]

(18) A "benefit period" for hospice care services is a period of three months, during which services are provided on a regular basis.

(19) A "hospice per diem" rate is the predetermined rate for each day in which an individual is enrolled in a hospice program and under its care, without regard to which, if any, services are actually provided on a specific day.

B. General Provisions Pertaining to Hospice Care

(2) The policy offering shall provide that benefits are allowed only for individuals who are terminally ill and have a life expectancy of six months or less, except that benefits may exceed six months should the patient continue to live beyond the prognosis for life expectancy, in which case the benefits shall continue at the same rate for one additional benefit period. *After the exhaustion of three benefit periods, the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care*. [Emphasis added.]

C. Benefits for Hospice Care Services

(2) The policy or certificate may contain a dollar limitation on routine home care hospice benefits. Other services provided by or through the hospice that are available to the insured will be negotiated at a hospice per diem

rate with the hospice provider. *Any policy offered shall provide a benefit of no less than $100 per day* for any combination of the following routine home care services, which are planned, implemented and evaluated by the interdisciplinary team:

The total benefit for each benefit period for these services shall not be less than the per diem benefit multiplied by ninety-one (91) days. [Emphasis added.]

(3) *The policy offering shall include the following benefits, subject to the policy's deductible, coinsurance and stoploss provisions, which are exclusive of and shall not be included in the dollar limitation for hospice care benefits as specified in (2) above*: [Emphasis added.]

(a) Bereavement support services for the family of the deceased person during the *twelve month period following death,* and in no event shall this maximum benefit be less than $1150. [Emphasis added.]

(b) Short-term general inpatient (acute) hospice care or continuous home care which may be required during a period of crisis, for pain control or symptom management and shall be paid consistent with any other sickness or illness (i.e., not included in the per diem limitation specified in (2) above). Such care shall require prior authorization of the interdisciplinary team and may, except for emergencies, weekends or holidays, require prior authorization by the insurer, provided, however, that the insurer may not require prior authorization when the transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day;

(c) Medical supplies;

(d) Drugs and biologicals;

(e) Prosthesis and orthopedic appliances;

(f) Oxygen and respiratory supplies;

(g) Diagnostic testing;

(h) Rental or purchase of durable equipment;

(i) Transportation;

(j) Physicians services;

(k) Therapies including physical, occupational and speech; and

(l) Nutritional counseling by a nutritionist or dietitian.

The Company's most frequently sold policy in Colorado in 2002 does not appear to reflect correctly the criteria for and extent of coverage for home health services and hospice care in the following ways:

- The Company's policy reflects that prior hospitalization is a prerequisite to receiving home health care.

- The description of covered charges contains an exclusion that does not appear to be in compliance with Colorado insurance law as it is unlawful to deny reimbursement for covered benefits when lawfully performed by a licensed provider who is also a family member or resides in the covered person's home.

The wording on page 11 of the policy is:

(11) Home Health Care. Covered Charges include:

To be covered, they must:

(c) begin within fourteen (14) days of a covered Hospital confinement of at least three (3) days.

A person who serves as a nurse, therapist or home health aide cannot:

(a) normally live in the Covered Person's home; or
(b) be related to the Covered Person by blood or marriage

- The explanation of who may receive bereavement support services appears to be more limiting than allowed by Colorado insurance law. A patient/family is to be one unit of care consisting not only of the immediate family, but also the primary care giver and individuals with significant personal ties.

The wording on page 11 and page 12 of the policy is:

COVERED CHARGES.

Covered Charges are:

(12) Hospice Care Services. Covered Charges include:

(c) a benefit of up to $1,150.00 for the expense incurred for bereavement counseling during the twelve (12) month period following the death of a person covered by this Policy, for counseling of the Covered Person's immediate family.

The wording on page 1 of the Hospice and Health Care Rider is:

DEFINITIONS

"Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered to the family unit during the three month period following death.

The wording on page 2 of the Hospice and Health Care Rider is:

BENEFITS

HOSPICE CARE:

(c) We will also pay a benefit of up to $1,150.00 for the expense incurred for bereavement counseling during the twelve month period following the death of a person covered by this Policy, for counseling of the Covered Person's immediate family.

- Both the policy and the benefit section of the Hospice and Health Care Rider reflect the correct twelve (12) month period following death for bereavement support services to be provided. However the definitions section of the Rider reflects an incorrect (as of February 1, 2001) period of three (3) months following death for bereavement support services to be provided.

The wording on page 1 of the Hospice and Health Care Rider is:

DEFINITIONS

Bereavement" is that period of time during which survivors mourn a death and experience grief. Bereavement services mean support services to be offered to the family unit during the three month period following death.

- An incorrect maximum benefit period of thirty (30) days of care is reflected for short-term inpatient hospice or continuous home care which may be required during a period of crisis, for pain control or for acute intervention alternatives and chronic symptom management. This limitation was eliminated as of February 1, 2001 with a requirement that the benefits are to be paid consistent with any other sickness or illness, (i.e., not included in the per diem limitation). The description of this benefit also appears to be incomplete in the following two (2) ways:

    - There is nothing reflected concerning the two (2) exceptions (weekends and holidays) for obtaining advance authorization for short-term general inpatient (acute) hospice care or continuous home care during a period of crisis, for pain control or symptom management.

    - There is nothing reflected to indicate that prior authorization may not be required if transfer to the higher level of care was necessary during the insurer's non-business hours if the hospice seeks the authorization during the insurer's first business day.

The wording on page 12 of the policy and page 2 of the Hospice and Health Care Rider is:

Policy

COVERED CHARGES.

Covered Charges are:

Rider

BENEFITS

HOSPICE CARE:

(12) Hospice Care Services. Covered Charges include:

(b) (We will also pay) benefits for short-term inpatient care, other than in a Hospital, or for continuous Home Health Care which may be required during a period of crisis for pain control or for acute intervention alternatives and chronic symptom management, for up to 30 days in a lifetime. Such care shall require prior authorization of the Interdisciplinary Team and may, except for emergencies, require prior authorization by the company.

- An incorrect statement appears to be reflected with reference to hospice care benefits being automatically limited to a maximum of 270 days. Colorado insurance law requires that after the exhaustion of three (3) benefit periods, (270 days) the insurer's case management staff shall work with the individual's attending physician and the hospice's Medical Director to determine the appropriateness of continuing hospice care.

The wording on page 11, (12) (a) of the policy and page 2, (a) of the Hospice and Health Care Rider is:

Policy

COVERED CHARGES.

Covered Charges are:

Rider

BENEFITS

HOSPICE CARE:

(We will pay) up to 270 days per Covered Person. …

- Nothing is reflected in either the policy or the Hospice and Health Care Rider to indicate that there is a minimum hospice per diem rate of no less than $100 per day that is subject to the policy's deductible, coinsurance and stoploss provisions.

- Nothing is reflected in either the policy or the Hospice and Health Care Rider to indicate that the total benefit for each benefit period is to be calculated as no less than the per diem benefit multiplied by ninety-one (91) days ($9,100).

- Nothing is reflected in either the policy or the Hospice and Health Care Rider to indicate that there are twelve (12) benefits which are subject to the deductible, coinsurance and stoploss provisions, but are exclusive of and not to be included in the dollar limitation for hospice care per diem benefits.

- Nothing is reflected in either the policy or the Hospice and Health Care Rider concerning the fact that "Home care services" are hospice services, to be provided in the place the patient designates as his/her primary residence, which may be a private residence, retirement community, assisted living, nursing or Alzheimer facility.

- Although a correct definition of a "Hospice" is contained in the Company's Hospice and Health Care Rider, the definition of a "Hospice Unit" in the Company's most frequently sold policy in Colorado in 2002 appears to be more restrictive than allowed under Colorado insurance law. A hospice is only required to be any facility or service that is licensed as such by the Department of Public Health and Environment.

The wording on page 3 and page 5 of the policy is:

DEFINITIONS

HOSPICE UNIT. A facility that:

(2) is separate from any other facility or is a separate place in a Hospital, designated only for providing Hospice Care;

(3) admits at least two (2) unrelated persons who are expected to die within six (6) months;

- A lifetime benefit maximum for Hospice Care Services is reflected in the policy that appears to be a more limited amount than required by Colorado insurance law. The hospice per diem benefit for each benefit period of three months is to be no less than $9,100 and there is a requirement to provide, if needed, three (3) benefit periods with a determination to be made at that time of the appropriateness of continuing hospice care. The three benefit periods produce an amount of $27,300 and there are additional benefits to be provided that are not included in the hospice per diem rate.

The wording on page 22 of the policy schedule is:

LIFETIME BENEFIT MAXIMUMS (for each Covered Person)

Hospice Care Services	[$10,000]

Form Number	Form Name
P283CO	Individual Major Medical Policy
B106	Hospice and Health Care Rider

Recommendation No. 11:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S., and Amended Regulation 4-2-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable policy forms to reflect correctly the criteria for and extent of coverage to be provided for home health services and hospice care as required by Colorado insurance law.

Issue E10: Failure to reflect correct or complete preventive child health supervision service benefits.

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, *"child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2)*, to dependent children up to age thirteen. [Emphasis added.] Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. …

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., states:

Attachment 1

COVERED PREVENTIVE SERVICES	
All Children	Immunization deficient children are not bound by "recommended ages" on immunization chart
Age 0-12 months	1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
Age 13-35 months	2 well child visits

The benefits for Child Health Supervision Service Benefits reflected in the Company's most frequently sold policy in Colorado in 2002 do not appear to be in compliance with the requirements of Colorado insurance law. The first two items on the following list, (coverage and information concerning coverage), are not reflected and the third item describes an incorrect age group that is reflected.

1. 1 newborn home visit during the first week of life if the newborn is released from the hospital less than 48 hours after delivery.
2. Immunization deficient children are not bound by "recommended ages" on immunization chart.
3. The required age grouping of 13-35 months for two (2) well child visits is reflected as 13-24

months and the next age grouping is for 3-6 years. This indicates there are no child health supervision service benefits available for two year old children.

The wording on page 14 and page 15 of the policy is:

BENEFIT PROVISIONS

(20) Children's Preventive Health Care. Covered Charges include the following visits and services.

All Children	Immunizations (recommended by the American Academy of Pediatrics)
0-12 months	five (5) Well-child visits, 1 PKU
13-24 months	two (2) Well-child visits
3-6 years	three (3)Well-child visits
7-12 years	three (3) Well-child visits
13 years and older	two (2) age appropriate health maintenance visits

Child health supervision services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one (1) visit by or under the supervision of a single Physician, Physician's Assistant, or registered nurse. These Covered Charges are not subject to the Deductible.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 12:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-104, C.R.S., and Amended Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect correct and complete preventive child health supervision service benefits as required by Colorado insurance law.

Issue E11: Failure to reflect correct information in the CoverColorado Notice Form.

Amended Regulation 4-6-3, Concerning CoverColorado Standardized Notice Form And Eligibility Requirements, promulgated by the Commissioner of Insurance under the authority of §§ 10-1-109 and 10-8-520, C.R.S., states:

> Section 4. Rules
>
> C. Elements of the CoverColorado Notice Form for Adverse Underwriting Decisions
>
> The elements of notification as determined by the Commissioner, which must be given to individuals with adverse underwriting decisions are:
>
> Applicant/Insured's:
>
> 1. Name.
>
> 2. Policy number (if applicable).
>
> 3. Reasons for notice: rejection of coverage, health rate higher than the rate available through CoverColorado or coverage that will be reduced by a restrictive rider or by excluding coverage for a pre-existing condition longer than six months or involuntarily terminated for reasons other than nonpayment of premium.
>
> 4. That the individual and dependents are eligible for the health care coverage through CoverColorado.
>
> 5. Name, address, contact person, and telephone number of CoverColorado Administrative Office to whom interested persons should be referred.
>
> 6. Name and telephone number of underwriter or other contact at the carrier's office.
>
> 7. A statement that the applicant may receive information about the available CoverColorado benefits and exclusions by contacting the CoverColorado Administrative Office.

Bulletin No. 13-01, Concerning CoverColorado Standardized Notice Form For Health Insurers, states:

> III. Division Position
>
> Effective January 1, 2002, all carriers authorized to conduct business in Colorado and offer health benefit plans are to provide the attached CoverColorado Notice Form to individuals who are eligible for coverage under the Colorado Uninsurable Health Insurance Plan as prescribed under 10-8-513, C.R.S.

This form is attached to this Bulletin as Exhibit A. Reproduction by insurers is authorized. Insurers may print the CoverColorado Plan Notice form on their own stationary but *should use the order, format and content as specified*. [Emphasis added.]

EXHIBIT A

COVERCOLORADO PLAN NOTICE FORM

The CoverColorado plan is available to Colorado residents. We believe that you may qualify for health insurance from CoverColorado for the reason(s) listed below:

4. You had a health plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of premium and is effective within the sixty-two (62) days after termination of such individual's prior coverage; or

5. You meet the definition of a federally eligible individual under Colorado Revised Statute 10-16-105.5, and are not subject to the eligibility requirements of Colorado Revised Statute 10-8-513. A dependent of a federally eligible individual shall be eligible for coverage under CoverColorado if the dependent satisfies the definition of "dependent" under Colorado Revised Statute 10-16-102(14). A federally eligible individual means an individual:

    a. Who has of the date on which the individual seeks coverage, the aggregate of periods of creditable coverage is eighteen months or more and the most recent prior creditable coverage was under a group health plan. As used in definition, "group health plan" means an employee welfare benefit plan as defined in 29 U.S.C., Sec. 1002(1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health care services, including items and services paid for as health care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "Group Health plan" includes a government or church plan.

    b. Who is not eligible for coverage under a group health benefit plan, Medicare, or Medicaid and does not have other health benefit plan coverage;

    c. Whose most recent coverage was not terminated as a result of nonpayment of premium or fraud; and

    d. Who did not turn down an offer of continuation coverage if it was offered and who subsequently exhausted such coverage.

For more information regarding CoverColorado, please contact:

CoverColorado
425 S. Cherry Street # 160
Glendale, CO 80246

The Company's CoverColorado Standardized Notice Form For Health Insurers does not appear to reflect correct or complete content in the following ways:

Incorrect: The address reflected in the Form given to the examiners with other policy forms and used for obtaining information about the CoverColorado program is:

Cover Colorado
1700 Broadway, Suite 430
Denver, CO 80290
303-863-1960

The CoverColorado Standardized Notice Form for Health Insurers that was used in all applicable files in the sample of Applications-New Business in 2002, reflects an incorrect address and telephone number for obtaining information about the CoverColorado program and refers to the program as Colorado Uninsurable Health Insurance Plan. The address and telephone number reflected are:

Colorado Uninsurable Health Insurance Plan
Philadelphia American Life Insurance Company
P.O. Box 2465
Houston, TX 77252
1 800 672-8447

The correct address effective as of April 1, 2002 was:

CoverColorado
425 S. Cherry Street # 160
Glendale, CO 80246
303-863-1960

Incomplete: The following reasons requiring the CoverColorado Notice Form are not reflected:

4. You had a health plan involuntarily terminated by a carrier in this state for any reason other than nonpayment of premium and is effective within the sixty-two (62) days after termination of such individual's prior coverage; or

5. You meet the definition of a federally eligible individual under Colorado Revised Statute 10-16-105.5, and are not subject to the eligibility requirements of Colorado Revised Statute 10-8-513. A dependent of a federally eligible individual shall be eligible for coverage under CoverColorado if the dependent satisfies the definition of "dependent" under Colorado Revised Statute 10-16-102(14). A federally eligible individual means an individual:

    a. Who has of the date on which the individual seeks coverage, the aggregate of periods of creditable coverage is eighteen

months or more and the most recent prior creditable coverage was under a group health plan. As used in definition, "group health plan" means an employee welfare benefit plan as defined in 29 U.S.C., Sec. 1002(1) of the federal "Employee Retirement Income Security Act of 1974" to the extent that the plan provides health care services, including items and services paid for as health care services, to employees or their dependents directly or through insurance reimbursement or otherwise. A "Group Health plan" includes a government or church plan.

b. Who is not eligible for coverage under a group health benefit plan, Medicare, or Medicaid and does not have other health benefit plan coverage;

c. Whose most recent coverage was not terminated as a result of nonpayment of premium or fraud; and

d. Who did not turn down an offer of continuation coverage if it was offered and who subsequently exhausted such coverage.

Form Number	Form Name
None	CoverColorado Notice Form (Company uses a letter)

Recommendation No. 13:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-3. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its CoverColorado Notice Form to reflect correct information as required by Colorado insurance law.

Issue E12: Failure to reflect correct information concerning non-renewal of health benefit plans.

Section 10-16-201.5, C.R.S., Renewability of health benefit plans – modification of health benefit plans, states:

(1) A carrier providing coverage under a health benefit plan shall not discontinue coverage *or refuse to renew such plan except for the following reasons*: [Emphasis added.]

(a) Nonpayment of the required premium;

(b) Fraud or intentional misrepresentation of material fact on the part of the plan sponsor with respect to group health benefit plan coverage and the individual with respect to individual coverage;

(d)(I) The carrier elects to discontinue offering and nonrenew all of its individual, small group, or large group health benefit plans delivered or issued for delivery in this state. In such case the carrier shall provide notice of the decision to discontinue or not to renew coverage to all policyholders and covered persons and to the insurance commissioner in each state in which an affected individual is known to reside at least one hundred eighty days prior to the discontinuance or nonrenewal of the health benefit plan by the carrier. The carrier shall also discontinue and nonrenew all of its individual or small or large group health benefit plans in Colorado. *Notice to the insurance commissioner under this paragraph (d) shall be provided at least three working days prior to the notice to the affected individuals*. [Emphasis added.]

(f) *With respect to individual health benefit plans, the commissioner finds* that the continuation of the coverage would not be in the best interest of the policyholders or certificate holders, the plan is obsolete, or would impair the carrier's ability to meet its contractual obligations. *Once the commissioner has made such a finding, the carrier shall provide notice to each covered individual provided coverage of this type of such discontinuation at least ninety days prior to the date of discontinuation* and shall provide each affected covered individual the opportunity to purchase any other individual health insurance coverage being offered by the carrier. [Emphases added.]

(4) An individual health benefit plan *must clearly disclose in its contracts and marketing materials the conditions of renewability which conform with the requirements of this section.* [Emphasis added.]

The Company's most frequently sold plan in Colorado for 2002, does not appear to reflect correct information concerning non-renewal of health benefit plans in the following way:

Incorrect:

The policy reflects the following incorrect reason for non renewal of health benefit plans:

> You no longer work or reside in the Service Area.

Using a ninety (90) day prior notification of non-renewal of a particular form of individual health plan and offer of any other coverage of the same type is not a decision that can be made solely at the discretion of the Company. This can only be done if one of three (3) specific situations is a finding of and approved by the Commissioner.

The wording on pages 1 and 2 of the policy is:

RENEWAL AGREEMENT

This Policy is renewable or will continue in force, at Your option unless:

(2) We refuse to renew all Policies of this form in Your state of residence, and send You written notice of such refusal at least ninety (90) days before Your premium is due. In this case, We will offer You, regardless of Your health, any other Policy We then offer in the individual market. If We send You and the applicable State authority written notice of nonrenewal at least one hundred eighty (180) days before Your premium is due, no offer of other coverage will be given.

(4) You no longer work or reside in the Service Area.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 14:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-201.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policies to reflect correct information, as required by Colorado insurance law, concerning non-renewal of both a particular health benefit plan and non-renewal of all plans delivered or issued for delivery in Colorado.

Issue E13: Failure to reflect correct information concerning coverage for preexisting conditions.

Section 10-16-118, C.R.S., Limitations on preexisting condition limitations, states:

(1) A health coverage plan that covers residents of this state:

(a)(II) If it is an individual health benefit plan, or a group health coverage plan to which subparagraph (I) of this paragraph (a) does not apply, *shall not deny, exclude, or limit benefits for a covered individual because of a preexisting condition for losses incurred more than twelve months following the effective date of coverage* …

The Company's most frequently sold policy in Colorado in 2002 reflects a statement concerning preexisting condition limitations that does not appear to be in compliance with Colorado insurance law. Coverage for preexisting conditions can be excluded for twelve (12) months from the effective date of a policy, but cannot be excluded entirely.

The wording on page 1 of the policy is:

> THIS POLICY DOES NOT PROVIDE PORTABILITY OF PRIOR COVERAGE. AS A RESULT, ANY INJURY, SICKNESS OR PREGNANCY FOR WHICH YOU HAVE INCURRED CHARGES, RECEIVED MEDICAL TREATMENT, CONSULTED A HEALTH CARE PROFESSIONAL, OR TAKEN PRESCRIPTION DRUGS WITHIN TWELVE (12) MONTHS OF THE EFFECTIVE DATE OF THIS POLICY WILL NOT BE COVERED UNDER THIS POLICY.

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 15:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-118, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect correct information regarding exclusion of coverage for preexisting conditions in compliance with Colorado insurance law.

Issue E14: Failure to reflect a correct limiting age for full-time students to remain covered as dependents.

Section 10-16-102(14), C.R.S., Definitions, states:

> "Dependent" means a spouse, an unmarried child under nineteen years of age*, an unmarried child who is a full-time student under twenty-four years of age* and who is financially dependent upon the parent, and an unmarried child of any age who is medically certified as disabled and dependent upon the parent. [Emphasis added.]

The Company's most frequently sold policy in Colorado in 2002 appears to reflect a requirement for an unmarried full-time student to remain covered as a dependent that is more restrictive than allowed by Colorado insurance law. Coverage may be continued until the student becomes twenty-four (24) years of age instead of twenty-three (23) years of age.

The wording on page 2 and page 3 of the policy is as follows:

COVERED PERSONS

> **…** An unmarried full-time student may stay on the Policy *until age 23* … [Emphasis added.]
>
> When a child marries or *becomes* 19 *(23, if an unmarried full-time student*) … [Emphasis added.]

Form Number	Form Name
P283CO	Individual Major Medical Policy

Recommendation No. 16:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its policy forms to reflect the correct limiting age, as required by Colorado insurance law, for full-time students to remain covered as dependents.

Issue E15: Failure to reflect correct or complete questions on the form used for determining whether or not an applicant is a self-employed business group of one.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

(1)(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans shall not apply to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor if, pursuant to rules adopted by the commissioner, all of the following conditions are met:

(A) As part of the application process, the carrier determines whether or not the applicant is a self-employed person who meets the definition of a business group of one pursuant to section 10-8-602 (2.5).

Amended Regulation 4-2-19, Concerning Individual Health Benefit Plans Issued To Self-Employed Business Groups Of One, promulgated pursuant to Sections 10-1-109(1), 10-8-601.5(1)(c)(1) and (3), 10-16-108.5(8), and 10-16-109, C.R.S., states:

V. Rules

A. An individual health benefit plan marketed and/or newly issued on or after October 1, 1997, to a self-employed business group of one, together with the dependents of the self-employed business group of one, shall be regulated as an individual health benefit plan instead of a small group health plan if the carrier issuing such policy, the policy itself, and the application for coverage meet all the following conditions:

1. Pursuant to Section 10-8-601.5(1)(c)(1)(A), C.R.S., the carrier issuing the policy shall determine whether or not the applicant is a self-employed business group of one. A carrier shall meet this requirement by having all applicants fill out the "Determination of Self-Employed Business Group of One Form" available from the Colorado Division of Insurance. A copy of the completed form shall be kept on file with each application. … Applicants who answer "yes" to all the questions in the form and, if required by the carrier, who can document their answers shall be considered to have met the test of a self-employed business group of one.

Bulletin No. 12-01, Determination of Self-Employed Business Group of One Form and Disclosure form for Self-Employed business Groups of One Applying for Individual Health Benefit Plans, states:

I. Background and Purpose

The purpose of this bulletin is to provide the form and disclosures required in Colorado Division of Insurance Regulation 4-2-19.

II. Applicability and Scope

This bulletin only applies to carriers offering and issuing individual health benefit plans to self-employed business groups of one *on or after January 1, 2002*. [Emphasis added.]

III. Division Position

A. Existing law requires an individual carrier to have all applicants complete the "Determination of Self-Employed Business Group of One Form" prior to issuance of an individual policy. The bulletin provides the required form. The form is provided in Attachment I of this bulletin.

Attachment I

Determination of Self-Employed Business Group of One Form

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?

___ Yes
___ No

2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?

___ Yes
___ No

3. Do you have *gross income* from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? *Note: Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.* [Emphases added.]

___ Yes
___ No

4. *Do you work a minimum of 24 hours a week on a permanent basis?* [Emphasis added.]

___ Yes
___ No

I, [name of applicant], attest that the answers to the questions contained in this form are true and correct.

Signature of Applicant: _____

Applicant's business: _____

Date: _____

The "Determination of Self-Employed Business Group of One Form" being used by the Company in 2002 does not appear to reflect correct or complete questions for this determination to be made. The words "taxable income" are used instead of "gross income" and there is no explanation of what constitutes a "substantial part of your income".

Question 3 on the Company's form reads:

> Do you have taxable income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes which generate taxable income in one of the two previous years?

Question 4 on the Company's form reads:

> Have you derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?

There is no question on the Company's form asking if the applicant works a minimum of 24 hours a week on a permanent basis.

Form Number	Form Name
PM-1790	Determination of Self-Employed Business Group of One Form

Recommendation No. 17:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. and Amended Regulation 4-2-19. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its "Determination of Self-Employed Business Group of One Form" to reflect correct and complete questions for making this determination as required by Colorado insurance law.

UNDERWRITING APPLICATIONS FINDINGS

Issue G1: Failure to use required disclosure forms to allow exemption from provisions required of small group plans when selling individual plans to Business Groups of One.

Section 10-8-601.5, C.R.S., Applicability and scope, states:

(1)(a) Except as provided in paragraphs (b), (c), and (c.5) of this subsection (1), this article and article 16 of this title shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(I) *Any portion of the premium or benefit is paid by or on behalf of a small employer*; [Emphasis added.]

(c)(I) Effective October 1, 1997, the provisions of this article and article 16 of this title concerning small employer carriers and small group plans *shall not apply* to an individual health benefit plan newly issued to a business group of one that includes only a self-employed person who has no employees, or a sole proprietor who is not offering or sponsoring health care coverage to his or her employees, together with the dependents of such a self-employed person or sole proprietor *if, pursuant to rules adopted by the commissioner, all of the following conditions are met*; [Emphasis added]

(E) As part of its application form, an individual carrier requires a business group of one self-employed person purchasing an individual health benefit plan pursuant to this subparagraph (I) *to read and sign a disclosure form* stating that, by purchasing an individual policy instead of a small group policy, such person gives up what would otherwise be his or her right to purchase a business group of one standard, basic, or other health benefit plan from a small employer carrier for a period of three years after the date the individual health benefit plan is purchased, unless a small employer carrier voluntarily permits such person to purchase a business group of one policy within such three-year period. [Emphasis added] The disclosure form shall also briefly describe the factors used to set rates for the individual policy being purchased in comparison with the factors used to set rates for a business group of one small group policy. The individual carrier *shall provide to the business group of one self-employed applicant a copy of the health benefit plan description form for the Colorado standard health benefit plan* in addition to the description form for the individual plan being marketed. [Emphasis added] The disclosure form may be included within any other certification form that the carrier uses for the plan. The division of insurance shall make available a standard plan description form to individual carriers upon request.

The Company does not appear to meet the conditions of Colorado insurance law for its plans to be exempt from small group provisions when selling individual health plans to Business Groups of One in the following ways:

1. The company has indicated it has no "disclosure form" to be read and signed by all applicants determined to be Business Groups of One who are purchasing individual health benefit plans.

2. The Company has indicated it has no Standard Health Benefit Plan description form that is to be provided to a Business Group of One applicant in addition to the Colorado Health Plan Description Form for the plan being marketed.

Recommendation No. 18:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-8-601.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that necessary exemption forms are obtained from applicants and that a standard health benefit plan description form is provided to applicants, as required by Colorado insurance law when selling individual plans to Business Groups of One.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure to send Certificates of Creditable Coverage within a reasonable time period.

Amended Regulation 4-2-18, Concerning The Method of Crediting and Certifying Creditable Coverage For Pre-existing Conditions, promulgated by the Commissioner under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S., states:

II. Purpose And Background

The purpose of this regulation is to establish the method health coverage plans must use to credit and certify creditable coverage when determining exclusions for pre-existing conditions as required by Section 10-16-118(1)(b), C.R.S. The purpose of the 1999 amendments to this regulation is to update the regulation as part of the Executive Order Review Process (Executive Order D0004 97).

III. Applicability And Scope

This amended regulation shall apply to all health coverage plans which are issued or renewed on or after November 1, 1999.

V. Rules

A. Application of federal laws concerning creditable coverage

1. The method for crediting and certifying creditable coverage for determining pre-existing condition limitations, as required by Section 10-16-118(1)(b), C.R.S., shall be as set forth in federal regulations promulgated pursuant to HIPAA, with the following exceptions:

   a. Those exceptions specifically enumerated in this regulation; and

   b. Where Colorado law exists on the same subject and has different requirements that are not pre-empted by federal law, Colorado law shall prevail.

2. The federal regulations found in 45 C.F.R. 146.113(a)(3), (b) and (c); 45 C.F.R. 146.115; 45 C.F.R. 146.117: 45 C.F.R. 146.119(b); and 45 C.F.R. 146.125 (a)(3), (b) (d) and (e) adopted by the Department of Health and Human Services are hereby incorporated by reference, and shall have the force of Colorado law, in accordance with Section 24-4-103(12.5), C.R.S. These federal regulations concern methods of counting creditable coverage, requirements concerning a health plan's duty to provide certificates of creditable coverage to insureds, special enrollment periods, the effective dates for certification requirements, transition rules for counting creditable coverage, and transition rules for certificates of creditable coverage. This rule does not include later amendments to, or editions of, the above-referenced regulations. Interested parties are encouraged to refer to the summary and supplementary information concerning the incorporated regulations which begins in Volume 62,

number 67, page 16894 of the Federal Register, April 8, 1997, for assistance in interpreting the federal regulations.

A random sample of fifty (50) cancelled/non-renewed files was chosen from the population of 136 files the Company provided as being terminated in 2002. Ten (10) of the sample files were short-term major medical policies and two (2) files were "Not Takens" which reduced the sample to thirty-eight (38) files. It does not appear that the Company is in compliance with Colorado insurance law in that nineteen (19) of the terminated files indicated that the Certificates of Creditable Coverage were not sent within a reasonable time period.

CANCELLED/NON-RENEWED FILES

Population	Sample	Number of Exceptions	Percentage to Sample
136	38	19	50%

Recommendation No. 19:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that after termination of coverage, Certificates of Creditable Coverage are provided within a reasonable time period in compliance with Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some cases, to pay, deny or settle claims within the time periods required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(1) The general assembly finds, determines, and declares that:

(a) Patients and health care providers often do not receive the reimbursements to which they are entitled from health insurance entities in a timely manner, even in the case of claims that are submitted on standard forms and do not require additional information for processing; and

(b) Unnecessary delays in the payment of routine and uncontested claims for reimbursement represent an unwarranted drain on health care providers' resources, which could be better spent attending to the needs of patients, as well as wasting the time and money of the patients themselves. Therefore, it is in the interest of the citizens of Colorado that reasonable standards be imposed for the timely payment of claims.

(2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of this section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Paid and Denied Claims Received Electronically in 2002 Exceeding 30 Days

Data provided by the Company indicated a population of 1,270 paid and denied individual claims received electronically in 2002. The examiners identified 100 claims from this population as taking over thirty (30) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these 100 files. Twenty-five (25) of the claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED ELECTRONIC CLAIMS OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
100	50	25	50%

(8% of all paid and denied electronic claims)

Paid and Denied Claims Received Non-Electronically in 2002 Exceeding 45 Days

Data provided by the Company indicated a population of 1,754 paid and denied individual claims received non-electronically in 2002. The examiners identified ninety-two (92) claims from this population as taking over forty-five (45) days from date of receipt to process. A randomly selected sample of fifty (50) claim files was taken from these ninety-two (92) files. Eighteen (18) of these claims do not appear to have been processed as required by Colorado insurance law with respect to the allowed time period.

PAID AND DENIED NON-ELECTRONIC CLAIMS OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
92	50	18	36%

(5% of all paid and denied electronic claims)

Paid and Denied Claims Received in 2002 Exceeding 90 Days

Data provided by the Company indicated 2,723 paid individual claims and 301denied individual claims received in 2002. The examiners identified forty-one (41) claims from this combined population of 3,024 as taking over ninety (90) days from date of receipt to process. None of these forty-one (41) claims appeared to involve fraud. These claims do not appear to have been paid, denied or settled as required by Colorado insurance law with respect to the ninety day time period.

CLAIMS NOT PAID, DENIED OR SETTLED WITHIN NINETY (90) DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
41	N/A	41	100%

(1% of all paid and denied claims)

Recommendation No. 20:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that all claims are paid, denied or settled within the time periods required by Colorado insurance law.

Issue J2: Failure to accurately determine the number of days utilized for claim processing.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states:

(4)(a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.

(b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such additional information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).

(c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

(5)(a) A carrier that fails to pay, deny, or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.

(b) A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.

Section 10-16-121, C.R.S., Required contract provisions in contracts between carriers and providers, states:

(1) A contract between a carrier and a provider or its representative concerning the delivery, provision, payment, or offering of care or services covered by a managed care plan shall make provisions for the following requirements:

(c) Any contract providing for the performance of claims processing functions by an entity with which the carrier contracts shall require such entity to comply with section 10-16-106.5 (3), (4), and (5).

The data being entered into the Company's claim system and used for computing the days from initial receipt of a claim until the check/explanation of benefits is mailed to the claimant (processing time) appears to be producing an incorrect number of days as indicated by the following procedures:

1. The Company uses Sloans Lake Managed Care as its PPO Network and repricing entity and has indicated that PPO claims received directly by Sloans are forwarded to Managed Health Funding (MHF) for processing after the claim has been repriced. The receipt date entered into the Company's system and used for calculating the days to process the claim, is the date MHF receives the repriced claim from Sloans Lake and not the initial receipt date by Sloans Lake.

2. The paid date being entered in the Company's system and used to compute the processing time for claims is the date the claims system adjudication is completed by the claims examiner. The check is generally cut and mailed the following business day which results in an additional one or two calendar days before the check is actually mailed.

These two procedures being used by the Company appear to result in an inability to accurately track the number of days utilized for processing of claims and to determine in all instances those for which late payment interest and penalties would apply. Carriers cannot avoid their statutory obligations regarding the amount of time allowed for processing claims without interest/penalty being due because an intermediary repricer is involved.

Recommendation No. 21:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-106.5 and 10-16-121, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established the necessary procedures to ensure compliance with Colorado insurance law in accurately determining the number of days used to process claims.

Issue J3: Failure, in some cases, to accurately process claims.

Section 10-3-1104(1), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

(f) Unfair discrimination states:

(II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

(h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part II or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:

(VI) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; . . .

Section 10-16-104, C.R.S., Mandatory coverage provisions, states:

(11) Child health supervision services.

(a) For purposes of this subsection (11), unless the context otherwise requires, "child health supervision services" means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to section 10-16-105 (7.2), to dependent children up to age thirteen . Such services shall be provided by a physician or pursuant to a physician's supervision or by a primary health care provider who is a physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a physician.

(b) An individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident that provides coverage for a family member of the insured or subscriber, shall, as to such family member's coverage, also provide that the health insurance benefits applicable to children include coverage for child health supervision services up to the age of thirteen. Each such plan shall, at a minimum, provide benefits for preventive child health supervision services. …

(c) Benefits for child health supervision services shall be exempt from a deductible or dollar limit provision in any individual, small group, or large group health benefit plan issued in Colorado or covering a Colorado resident and such exemption shall be explicitly stated in such a plan. …

INDIVIDUAL PAID CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
2,723	50	3	6%

INDIVIDUAL DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
301	50	4	8%

Randomly selected samples were chosen for review of processing from the population of individual paid and denied claims received from January 1, 2002 through December 31, 2002. The populations, sample sizes, number of exceptions and percentage to the sample are reflected above.

The following is a description of the claims that do not appear to have been processed correctly:

Comment Form No. J3

Denied Claim Sample
1. The claim was denied as a duplicate having been originally paid on May 20, 2002. The amount that had been paid was $900.00, which is the amount that was reflected on the Sloans Lake repricing sheet. A second repricing sheet was received on August 27, 2002 and reflected a repriced amount of $1,080 with a provider's handwritten request to "refer to their contract and pay per contract". It appears the additional amount of $180.00 should have been paid but no further action was taken on this claim. In response to the examiner's inquiry, the Company has agreed that the $180.00 is due and will be paid during the examination. It appears that late payment interest and a penalty would also be applicable.

Denied Claim Sample
2. The claim was originally received on August 19, 2002 and denied on August 26, 2002, with a reason of "no benefits are payable for services due to the elimination rider on your policy". After the claim was selected for the sample and when the Company claims auditor was assembling the requested file information, it was noted that a benefit of $53.18 should have been paid. A reconsideration of this claim was processed on December 12, 2003, however it does not appear that any late payment interest or penalty was paid.

Comment Form No. J3-First and Second Addendum

Paid Claim Sample
Three (3) claims for routine child health exams and immunizations for children under the age of two were processed under preventive care benefits with the allowable amount being applied to a calendar year maximum. These claims should have been processed under the mandated child health supervision services and exempt from a dollar limit provision.

Comment Form No. J3-Third Addendum

Denied Claim Sample
1. This claim was denied with a reason of "Charges incurred after the termination of your policy are ineligible". The date of service was 08/24/02. After the policyholder appealed a 08/02/02 termination for non-payment of premium, the policy was reinstated 10/14/02 with the letter of notification indicating reinstatement with no lapse in coverage. The insured was not removed from the policy until his death on 11/14/02. It appears this claim for $358.44 should have been paid.

Comment Form No. J3-Fourth Addendum

Denied Claim Sample
1. The original processing of this claim, for an infant, was paid as 1st year Preventive Care, Adult Immunizations with a $100 1st year benefit maximum. Although the claim form submitted reflected an adult as the patient, the birth date was reflected as 1900, the procedure codes and diagnosis codes indicated a routine child health exam with immunizations and the provider was a Youth Clinic. The sample claim, a resubmission was denied as a duplicate charge previously considered under the original claim number. Subsequently the claim was submitted a third time reflecting the dependent child as the patient, same services and the same date of service. This claim was processed with the entire eligible amount of $262.83 being paid, resulting in a $100.00 overpayment.

Recommendation No. 22:

Within 30 days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has established procedures to ensure that claim procedures are reviewed for accuracy of payment that is in compliance with Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

ISSUES	Rec. No.	Page No.
COMPANY OPERATIONS/MANAGEMENT – FINDINGS		
Issue A1: Failure to maintain an access plan as required by Colorado insurance law.	1	17
Issue A2: Certifying and using forms that do not comply with Colorado insurance law.	2	18
UNDERWRITING – POLICY FORMS – FINDINGS		
Issue E1: Failure to provide benefits for covered services based on a licensed provider's status, (e.g., a family member or residing in the home of the insured).	3	21
Issue E2: Failure to reflect correct or complete benefits for mammography screening.	4	23
Issue E3: Failure to reflect an accurate description of the mandated coverage for prostate cancer screening.	5	25
Issue E4: Failure to display a Fraud Warning that is substantially the same as required by Colorado insurance law.	6	26
Issue E5: Failure to disclose the existence and availability of an access plan in the most frequently sold policy in Colorado.	7	27
Issue E6: Failure to reflect correct information in the "Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance".	8	30
Issue E7: Failure to reflect correct information in application forms concerning replacement of coverage.	9	32
Issue E8: Failure to reflect an accurate description of the mandated therapies for congenital defects and birth abnormalities for children.	10	34
Issue E9: Failure to reflect correctly the criteria for and the extent of coverage to be provided for home health services and hospice care.	11	42
Issue E10: Failure to reflect correct or complete preventive child health supervision service benefits.	12	44
Issue E11: Failure to reflect correct information in the CoverColorado Notice Form.	13	48
Issue E12: Failure to reflect correct information concerning non-renewal of health benefit plans.	14	50
Issue E13: Failure to reflect correct information concerning coverage for preexisting conditions.	15	51
Issue E14: Failure to reflect a correct limiting age for full-time students to remain covered as dependents.	16	52

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